

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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FILED SEP 17 1941  
DEPARTMENT OF COMMERCE  
BUREAU OF CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 26604  
6396  
Registrar's No.

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town \_\_\_\_\_  
(c) Name of hospital or institution: 1030 Rutger Dr.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 1 yr. years, months or days

3. (a) PRINT FULL NAME Mable Weathers

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 1 1915  
(Month) (Day) (Year)

8. AGE: Years 26 Months 2 Days 29 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace E. St. Louis Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name John Weathers

13. Birthplace Cap. Bismarck Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name John Weathers

15. Birthplace Murphysboro Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant John Weathers

(b) Address E. St. Louis Ill.

17. (a) Removal (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Murphysboro Ill.

18. (a) Signature of funeral director Neil Walsh Barker

(b) Address E. St. Louis Ill.

19. (a) AUG - 5 1941 (b) J. H. (Bridick)  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1030 Rutger Dr.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 30  
year 1941 hour 9 minute 45 AM.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death: General Peritonitis following ruptured tubal pregnancy  
Due to ectopic pregnancy  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 12

Major findings: Of operations 12

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Alfred J. Perry (M. D. or other) 2

Address Cap. Bismarck Date signed 7/30/41

9639  
9639

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.  
working under my personal supervision.

Signed

*Howard P. Rowland*

Licensed Embalmer No.

*3114*

P. O. Address

*St. Louis*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **26694**

Registration District No. **791**

Primary Registration District No. **1603**

Registrar's No. **6396**

1. PLACE OF DEATH:

(a) County **St. Louis**  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community  
years, months or days)

3. (a) PRINT FULL NAME

**Mable Heathers**

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex 5. Color or race 6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name 13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name 15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) **Mar. 5, 1941** (b) **J. J. Bredeck** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **30** year **1941** hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19

that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death **Sev. peritonitis following ruptured tubal salpinx - Cause unknown (non-puerperal)** Duration

Due to Cause unknown (non-puerperal)

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of autopsy **152**

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Date signed

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision:

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**